NEW HAMPSHIRE MEDICAID

SCHALLER ANDERSON
MEDICAL ADMINISTRATORS, INCORPORATED

REQUEST FOR PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ **RECIPIENT DATE OF BIRTH:** ____/____/_____

DOES RECIPIENT HAVE ALTERNATE INSURANCE PLAN? ❑ YES ❑ NO **PART B** ❑ YES ❑ NO **In/Out?** ❑ YES ❑ NO

NAME OF INSURANCE PLAN: _____ **RECIPIENT MEDICAID ID:** _____

CPT CODE: _____ **DIAGNOSIS CODE:** _____ **DATE REQUESTED:** ____/____/_____

PROVIDER NAME: _____ **NH MEDICAID PROVIDER #:**_____

TELEPHONE #: (____) ___ - _____ **FAX #:** (____) ___ - _____ **CONTACT PERSON NAME:** _____

FACILITY/HOSPITAL: _____ **CONTACT PERSON #:** ( ) _____ - _____

PROCEDURE(S) BEING REQUESTED: ❑ With Contrast ❑ Without Contrast ❑ With & Without Contrast

- ❑ CT Head (Brain)
- ❑ CT Maxillofacial Area
- ❑ CT Orbit, Sella, Ear
- ❑ CT Soft-Tissue Neck
- ❑ CT Chest
- ❑ CT Chest (Follow Up)
- ❑ CT Cervical Spine (C-spine)
- ❑ CT C-Spine Post Myelogram
- ❑ CT Thoracic Spine (T-Spine)
- ❑ CT T-Spine Post Myelogram
- ❑ CT Lumbar Spine (L-Spine)
- ❑ CT L-Spine Post Myelogram
- ❑ CT Abdomen
- ❑ CT Abdomen (Follow Up)
- ❑ CT Renal Stone Survey
- ❑ CT Pelvis
- ❑ CT Upper Extremity
- ❑ CT Lower Extremity
- ❑ CT Guidance Procedure (Specify CPT Code/Describe) _____
- ❑ CT Angiography – Head
- ❑ CT Angiography – Neck
- ❑ CT Angiography – Chest
- ❑ CT Angiography – Abdomen
- ❑ CT Angiography – Pelvis
- ❑ CT Angiography – Upper Extremity
- ❑ CT Angiography – Lower Extremity
- ❑ CT Angiography – Abdominal Aorta & bilateral iliofemoral lower extremity runoff
- ❑ PET Scan – Limited Area
- ❑ PET Scan – Skull Base to Mid-Thigh
- ❑ PET Scan – Whole Body
- ❑ PET/CT Fusion Scan – Limited Area
- ❑ PET/CT Fusion Scan – Skull Base to Mid-Thigh
- ❑ PET/CT Fusion Scan – Whole Body
- ❑ PET Scan – Brain
- ❑ MRI Head (Brain)
- ❑ MRI Temporomandibular (TMJ) Joint
- ❑ MRI Orbit, Face Neck
- ❑ MRI Chest
- ❑ MRI Cervical Spine (C-Spine)
- ❑ MRI Thoracic Spine (T-Spine)
- ❑ MRI Lumbar Spine (L-Spine)
- ❑ MRI Abdomen
- ❑ MRI Pelvis
- ❑ MRI Upper Extremity Other Than Joint
- ❑ MRI Upper Extremity Any Joint
- ❑ MRI Lower Extremity Other Than Joint
- ❑ MRI Lower Extremity Any Joint
- ❑ MRI Cardiac (Heart)
- ❑ MRI Breast Unilateral
- ❑ MRI Breast Bilateral
- ❑ MRI Bone Marrow Blood Supply
- ❑ MR Guidance Procedure (Specify CPT Code/Describe) _____
- ❑ MR Angiography – Head
- ❑ MR Angiography – Neck
- ❑ MR Angiography – Chest Non Cardiac
- ❑ MR Angiography – Abdomen
- ❑ MR Angiography – Pelvis
- ❑ MR Angiography – Spinal Cana
- ❑ MR Angiography – Upper Extremity
- ❑ MR Angiography – Lower Extremity

NUCLEAR CARDIAC IMAGING

Myocardial Perfusion Imaging (MPI)

- ❑ MPI Tomographic SPECT Single Study
- ❑ MPI Tomographic SPECT Rest & Stress
- ❑ MPI Wall Motion
- ❑ MPI Ejection Fraction
- ❑ Cardiac Blood Pool Imaging (MUGA) (Single)
- ❑ PET Scan – Cardiac

CLINICAL INFORMATION:

Please attach clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Medical Care Plan, Relevant Diagnostic Tests, and Progress Notes.

CERTIFICATION OF MEDICAL NECESSITY
(to be signed by ordering physician requesting the service)

I certify that the requested treatments and /or procedures are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

_____ **Signature**

_____ **Date**

Please print:

_____ **Name/Title**

_____ **Specialty**

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

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